SUBMITTING CLAIMS TO MEDICAID

Time Limits for Filing Claims

All Medicaid claims, except inpatient claims and nursing facility claims, must be received by EDS within 365 days of the **first date** of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the **last date** of service on the claim.

Submitting Claims on Paper

When completing the paper claim form, use black ink only. Do not submit carbon copies or photocopies. EDS uses optical scanning technology to store an electronic image of the claim and the scanners cannot detect carbon copies, photocopies or any color of ink other than black. For auditing purposes, all claim information must be visible in an archive copy. Carbon copies, photocopies, and claims containing a color of ink other than black will not be processed and will be returned to the provider. This includes highlighting the claim or any portion of the claim.

Processing Paper Claims without a Signature

Providers are allowed to file **paper** claims without an original signature on each claim if the provider submits a **Provider Certification for Signature on File form**. Providers who file claims electronically are not required to complete this form. Refer below to **Submitting Claims Electronically**. Please note out of state providers, beyond 40 miles, are required to have a signature on the claim.

The form must contain the provider's original signature. Stamped signatures are not accepted. For group physician/practitioner practices or clinics, each attending provider must sign a certification. For groups such as home health, hospitals, facilities (including adult care), etc. that do not require an attending provider number on the claim, the certification should be signed by an individual who has authority to sign contracts on behalf of the provider.

To avoid EOB 1350 denials (which indicate that a **Provider Certification for Signature on File form** has not been submitted), please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888 prior to submitting claims to verify that the system has been updated.

A copy of the form is available on page 5-30 or on the DMA website at http://www.dhhs.state.nc.us/dma/forms.html. FAX or mail completed certifications two weeks in advance of submitting claims without a signature.

Submitting Claims Electronically

Providers who plan to submit claims electronically must indicate their intention to do so by agreeing to abide by the conditions for electronic submission outlined in the Electronic Claims Submission Agreement.

The process of submitting claims to Medicaid through electronic media is referred to as Electronic Commerce Services (ECS). EDS will process claims submitted through ftp and async dial-up.

Billing electronically requires software that complies with the transaction standards mandated by the Health Insurance Portability and Accountability Act (HIPAA). Refer to page 10-1 for additional information about electronic billing and ECS services.

Billing on the CMS-1500 Claim Form

Listed below are some of the provider types who bill Medicaid using the CMS-1500 claim form:

ambulatory surgery center*
audiology or speech pathology, physical therapy, occupational therapy, respiratory therapy
audiology or speech pathology, physical therapy, occupational therapy and psychological services, case management services (department of social services)
certified registered nurse anesthetist*
chiropractor*
community alternatives program
durable medical equipment*
federally qualified health center**
free standing birthing center*
head start
health department
hearing aid dealer
HIV case management
home infusion therapy
independent diagnostic testing facility*
independent laboratory*
independent mental health provider
independent practitioner
local education agency
mental health center
nurse midwife*
nurse practitioner*
optical supply dealer
optometrist*
orthotics and prosthetics*
personal care services
physician*
planned parenthood (non-medical doctor)*
podiatrist*
portable x-ray
private duty nursing services
residential evaluation services
rural health clinic**

***** Some provider types are mandated to bill Medicaid using modifiers. Please refer to the **April 1999 Special Bulletin II, *Modifiers***, for Medicaid modifier usage guidelines.

****** Modifier usage is subject to noncore services only.

Medicaid special bulletins are available on DMA's website at http://www.dhhs.state.nc.us/dma.bulletin.htm.

CMS-1500 Claim Form Instructions

Instructions for completing the standard CMS-1500 claim form are listed below.

Block	Block Name	Explanation
1.	**Type of Coverage**	Place an (X) in the Medicaid block**.**
1a.	**Insured's ID Number**	Enter the recipient's ten-character identification number found on the MID card.
2.	**Patient's Name**	Enter the recipient's full name (last name, first name, middle initial) exactly as it appears on the MID card.
3.	**Patient's Birth Date**	Enter the recipient's date of birth using eight digits (e.g., July 19, 1960 would be entered as 07191960). **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
	Sex	Place an (X) in the appropriate block to indicate the recipient's sex (M = male; F = female).

Block	Block Name	Explanation
5.	**Patient's Address** **Telephone**	Enter the recipient's street address including city, state, and zip code. Entering the recipient's telephone number is optional.
9.	**Other Insured's Name**	If applicable, enter private insurance information. For programs that use Medicare override statements, enter applicable statement.
10.	Is Patient's Condition Related To: **a. Employment?** **b. Auto Accident?** **c. Other Accident?**	If applicable, check the appropriate block.
15.	**If Patient Has Had Same or Similar Illness, Give First Date**	Leave blank **EXCEPT** when billing for: **OB Antepartum Care Package Codes:** Enter the first date recipient care was rendered for current pregnancy. **Health Check:** The next screening date (NSD) may be entered in block 15.
15.	**If Patient Has Had Same or Similar Illness, Give First Date**, continued	If the date the provider enters in block 15 is within the periodicity schedule, the system will keep this date. If the NSD entered by the provider is out-of-range with the periodicity schedule or the provider chooses one of the three options listed below, an appropriate NSD will be systematically entered during claims processing according to the Medicaid periodicity schedule. ● Leave block 15 blank ● Place zeros in block 15 (example – 00/00/0000) ● Place all ones in block 15 (11/11/1111) **Dialysis Treatment or Supervision:** Enter the dialysis start date. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
16.	Dates Patient Unable to Work in Current Occupation **"From" and "To"**	If billing for postoperative management only (designated by modifier 55 in block 24D), enter the "From" and "To" dates the provider was responsible for recipient's care. If the provider was responsible for care for nonconsecutive periods of time per follow-up period, multiple claims must be filed. Date spans cannot overlap with dates on another claim. Refer to the **April 1999 Special Bulletin II, *Modifiers***, for billing guidelines. Please be aware that Medicaid does not recognize any information in block 17 and 17a.

Block	Block Name	Explanation
19.	**Reserved for Local Use**	**For CA Enrollees:** Enter the PCP's referral authorization number. **For Area Mental Health Providers ONLY:** Enter the area mental health program reference number when applicable.
20.	**Outside Lab?**	Check "yes" or "no." "No" indicates that the lab work was performed in the office.
21.	**Diagnosis or Nature of Illness or Injury**	The written description of the primary diagnosis is not required unless using diagnosis code V900. However, the claim must be ICD-9-CM coded to describe the primary diagnosis.
23.	**Prior Authorization Number**	Any provider billing for laboratory services must enter the CLIA number in this field. It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file.
24A.	**Date(s) of Service "From" and "To"**	Enter the eight-digit date of service in the "From" block. **Example:** Record the date of service January 31, 2003 as 01312003. If the service consecutively spans a period of time, enter the beginning service date in the "From" block and the ending service date in the "To" block. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
24B.	**Place of Service**	Enter the appropriate code from the **Place of Service Code Index** on page 5-7.
24C.	**Type of Service**	Enter the appropriate code from the **Type of Treatment/Type of Service Code Index** on page 5-10. Note: Effective date of processing October 16, 2003, Type of Service will no longer be required.
24D.	**Procedures, Services, or Supplies**	Enter the appropriate five-digit CPT or HCPCS code. **Note:** Providers mandated to bill modifiers can bill up to three modifiers per procedure code, if applicable. Refer to the **April 1999 Special Bulletin II, *Modifiers***, for billing guidelines. Health Check claims may also contain modifiers. Refer to guidelines listed in the **April 2004 Special Bulletin I, *Health Check Billing Guide 2004***.
24F.	**Charges**	Enter the usual and customary charge for each service rendered.
24G.	**Days or Units**	Enter the number of visits or units.

Block	Block Name	Explanation
24H.	**EPSDT Family Plan**	If the service is the result of an EPSDT (Health Check) screening referral, enter "E." If the service is related to family planning, enter "F."
26.	**Patient's Account No.**	A provider has the option of entering either the recipient control number or medical record number in this block. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric) but only the first nine characters of this number will appear on the RA.
28.	**Total Charge**	Enter the total charges. (Medicaid is not responsible for any amount that the recipient is not responsible for if the recipient is private pay or has Third Party coverage.)
29.	**Amount Paid**	**For dates of service after October 1, 2002 but before September 6, 2004**, enter the total amount received from Medicare, or other third party payment source. (TPL) If there is a payment form Medicare and a TPL, leave block 29 blank and submit the claim with the appropriate EOB's attached. on including penalties and outpatient psychiatric reductions, and other third party payment source(s). Refer to the **September 2002 Draft Special Bulletin IV (Revised November 14, 2002)** ***Medicare Part B Billing Guidelines*** for detailed instructions on billing for Medicare Part B. **Effective with dates of service September 6, 2004**, professional charges will be reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B Reimbursement schedule. **Do not enter Medicare payments on the claim. Attach the Medicare voucher when the submitting the claim to Medicaid.** Refer to the **August 2004 Special Bulletin V,** ***Medicare Part B Billing*** for detailed instructions.
31.	**Signature of Physician or Supplier Including Degrees or Credentials**	The physician, supplier or an authorized representative must either: 1. sign and date all claims, or 2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or 3. if a **Provider Certification for Signature on File form** has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.

Block	Block Name	Explanation
33.	**Physician's or Supplier's Billing Name, Address, Zip Code & Phone #.**	Enter the billing provider's name, street address including zip code, and phone number. **PIN #:** Enter the attending physician's or orthotic and prosthetic certified seven-character Medicaid provider number. **GRP #:** Enter the seven-character group provider number used for Medicaid billing purposes. The provider number must correspond to the provider name above (i.e., if billing with a group number, use the group name entered in block 33).

Place of Service Code Index

POS Code	Description	Explanation
00-02	**Unassigned**	
03	**School**	A facility whose primary purpose is education.
04	**Homeless Shelter**	
05	**Indian Health Service Free-Standing Facility**	
06	**Indian Health Service Provider-Based Facility**	
07	**Tribal 638 Free-Standing Facility**	
08	**Tribal 638 Provider-Based Facility**	
09 – 10	**Unassigned**	
11	**Office**	Location, other than a hospital or nursing facility, where the health professional routinely provides health exams, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	**Home**	Home is considered the recipient's private residence, which also includes an adult care home facility.
13	**Assisted Living Facility**	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day. 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	**Group Home**	
15	**Mobile Unit**	
16 -19	**Unassigned**	
20	**Urgent Care Facility**	
21	**Inpatient Hospital**	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by or under the supervision of physicians to recipients admitted for a variety of medical conditions.
22	**Outpatient Hospital**	A section of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	**Emergency Department - Hospital**	A section of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	**Ambulatory Surgical Center**	A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

POS Code	Description	Explanation
25	**Free-Standing Birthing Center**	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborns.
26	**Military Treatment Facility**	A medical facility operated by one or more of the Uniformed Services Military Treatment Facilities (MTF). Also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27–30	**Unassigned**	
31	**Skilled Nursing Facility**	
32	**Nursing Facility**	A facility that provides nursing facility level of care of the elderly and physically disabled adults. This facility provides nursing and related services, and rehabilitation services to maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
33	**Custodial Care Facility**	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, which does not include a medical component.
34	**Hospice**	A facility, other than a recipient's home, in which palliative and supportive care for terminally ill recipients and families are provided.
35 40	**Unassigned**	
41	**Ambulance – Land**	
42	**Ambulance – Air or Water**	
43 48	**Unassigned**	
49	**Independent Clinic**	
50	**Federally Qualified Health Center**	
51	**Inpatient Psychiatric Facility**	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	**Psychiatric Facility Partial Hospitalization**	
53	**Community Mental Health Center**	A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
54	**Intermediate Care Facility/Mentally Retarded**	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or nursing facility.

Place of Service Code Index, continued

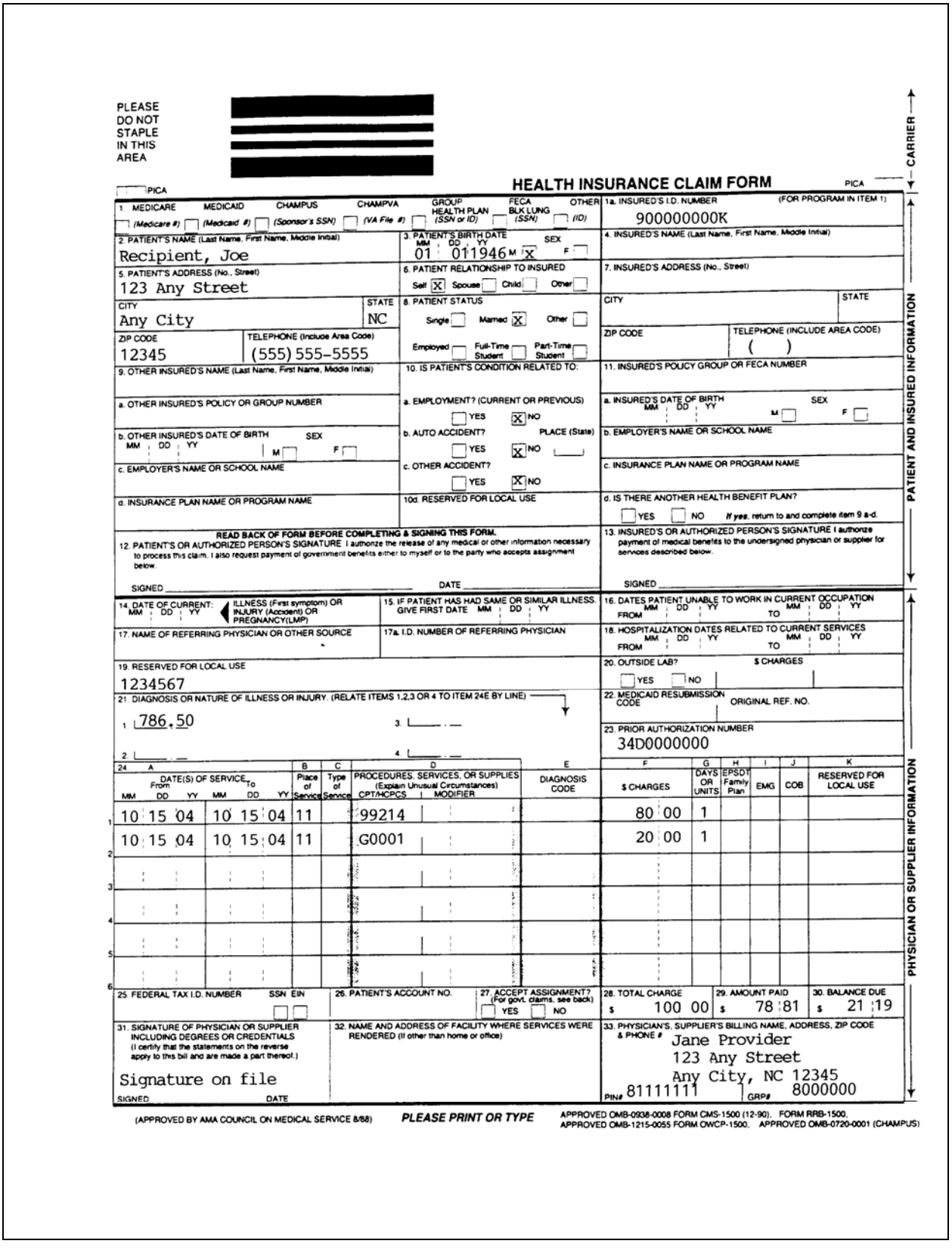
POS Code	Description	Explanation
55	**Residential Substance Abuse Treatment Facility**	
56	**Psychiatric Residential Treatment**	
57	**Non-residential Substance Abuse Treatment Facility**	
58 59	**Unassigned**	
60	Mass Immunization Center	
61	**Comprehensive Inpatient Rehabilitation Facility**	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitative nursing, physical therapy, speech pathology, social or psychological services, and orthotic and prosthetic services.
62	**Comprehensive Outpatient Rehabilitation Facility**	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63 64	**Unassigned**	
65	**End Stage Renal Disease Treatment Facility**	A facility other than a hospital, that provides dialysis treatment, maintenance or training to recipients or caregivers on an ambulatory or home-care basis.
66 70	**Unassigned**	
71	**State or Local Public Health Clinic**	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	***Rural Health Clinic***	A certified facility that is located in a medically underserved rural area that provides ambulatory primary medical care under the general direction of a physician.
73 80	**Unassigned**	
81	**Independent Laboratory**	A laboratory certified to perform diagnostic or clinical tests independent of an institution or a physician's office.
82 98	**Unassigned**	
99	**Other Unlisted Facility**	Other unlisted facilities not identified above, such as a school.

Type of Service Index

TOS	Description	Type of Service Conversion in Medicaid Claims Processing System
01	Medical	3
02	Surgical	3
03	Consultation	3
04	Diagnostic x-ray and lab, professional component	5
05	Diagnostic laboratory, complete procedure	3
06	Radiation therapy	5
07	Anesthesia	1
08	Assistant at surgery	2
09	Maternity	3
10	Eye exams	3
11	Dental	4
15	Independent practitioners, ambulatory surgery, visual aids, and hearing aids	9
31	Complete procedure (both professional and technical components)	3
E	Durable medical equipment - rental	B
N	Durable medical equipment - new purchase	6
T	Technical component	T
U	Durable medical equipment - used purchase	8

Note: Providers must utilize these TOS codes for the Automated Voice Response (AVR) system inquiries that ask for the type of treatment.

Sample CMS 1500 Claim Form



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 900000000K

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1946 | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Any City | STATE: NC

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: | STATE:

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE: | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: 1234567

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 786.50 3. 2. 4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 34D0000000

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 15 04	10 15 04	11		99214			80 00	1				
2 10 15 04	10 15 04	11		G0001			20 00	1				
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 100 00

29. AMOUNT PAID $ 78 81

30. BALANCE DUE $ 21 19

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on file

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Jane Provider
123 Any Street
Any City, NC 12345

PIN# 81111111 GRP# 8000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)

Sample CMS 1500 Claim Form

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Billing on the UB-92 Claim Form

Listed below are some of the provider types who bill on the UB-92 claim form:
adult care home
ambulance
area mental health
dialysis facilities
home health agency
hospice
hospital
intermediate care facility/mental retardation
nursing facility
psychiatric residential treatment facilities
residential child care facilities (level II, III, and IV)

UB-92 Claim Form Instructions

Instructions for completing the standard UB-92 standard claim are listed below.

Form Locator/Description	Requirements	Explanation
1. Provider Name/Address	Required	Enter the provider's name as it appears on the RA and up to three lines of the address. **Note:** Do not abbreviate the provider's name.
3. Patient Control Number	Optional	Enter either the recipient control number or medical record number, which the provider has selected to appear on their RA. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric) but only the first nine characters of this number will appear on the RA.
4. Type of Bill	Required Three Digits	Type of Facility - 1st Digit Hospital.....1 Skilled Nursing (SNF) .....2 Home Health .....….3 Intermediate Care (ICF).....6 Special Facility….....8* * If Type of Facility code 8 (Special Facility) is used, then use a Bill Classification for Special Facilities.

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
4. Type of Bill, continued	Required Three Digits	Bill Classification - 2nd Digit Inpatient (including Medicare Part A) .....1 Outpatient.....3 Other (for hospital referenced diagnostic services or home health not under a plan of treatment).....4 Intermediate Care - Level I Medicaid swing-bed ICF.....5 Intermediate Care - Level II Medicaid swing-bed SNF .....6 Subacute Inpatient.....7 Swing Beds Medicaid SNF inappropriate level of care.....8 Bill Classification - 2nd Digit (Clinics Only) Rural Health Clinic .....1 Independent and Provider Based FQHC.....3 Outpatient Rehab. Facility/Community Mental Health Center. 4 Comprehensive Outpatient Rehab. Facility .....5 Community Mental Health .....6 Bill Classification - 2nd Digit (Special Facilities Only) Hospice (nonhospital-based).....1 Hospice (hospital-based).....2 Ambulatory Surgery Center.....3 Free Standing Birthing Center .....4 Rural Primary Care Hospital.....5 Frequency - 3rd Digit Admit Through Discharge .....1 Interim - First Claim .....2 Interim - Continuing Claim .....3 Interim - Last claim.....4 Late Charge(s) - Only Claim.....5 Replacement of Prior Claim.....7 Void/Cancel of Prior Claim .....…8
5. Federal Tax Number	Required, where applicable	

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
6. Statement Covers Period "From" and "Through"	Required	Enter the eight-digit beginning service date in the "From" block. Enter the eight-digit ending service date in the "Through" block. **Example:** Record the date of service January 31, 2004 as 01312004. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
7. Covered Days	Required (Hospital/ Nursing Home)	Indicate the total number of days the provider is billing on this claim form.
9. Coinsurance Days	Required, where applicable	Indicate any coinsurance days during the period the provider is billing on this claim form.
10. Lifetime Reserve Days	Required, where applicable	Indicate any lifetime reserve days used for this period.
11.	Required, where applicable	**For electronic claims for services provided to CA enrollees, enter the PCP's referral authorization number here.** **For paper claims, enter the PCP referral authorization number in form locator 83b.**
12. Patient Name	Required	Enter recipient's full name exactly as shown on the MID card (last name, first name, middle initial).
13. Patient Address	Required	Enter the recipient's street address including city, state, and zip code.
14. Patient Birthdate	Required	Enter the recipients date of birth using eight digits **Example:** July 19, 1960 would be entered as 07191960. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
15. Patient Sex	Required	Enter one alpha character indicating the sex of the recipient. Valid characters are "M", "F", or "U."

UB-92 Claim Form Instructions, continued

<table>
<tr><th>Form Locator/Description</th><th>Requirements</th><th>Explanation</th></tr>
<tr><td>17. Admission Date</td><td>Required</td><td>Enter the eight-digit date that the recipient was admitted.

Example: Record the date January 31, 2004 as 01312004.

Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims.</td></tr>
<tr><td>18. Admission Hour</td><td>Required (hospital/ ambulance)</td><td>For multiple outpatient visits on the same day, indicate the admission hour and submit each visit on a separate claim.

<table>
<tr><th>Time Code</th><th>AM</th><th>Time Code</th><th>PM</th></tr>
<tr><td>00</td><td>12:00 – 12:59 midnight</td><td>12</td><td>12:00 – 12:59 noon</td></tr>
<tr><td>01</td><td>01:00 – 01:59</td><td>13</td><td>01:00 – 01:59</td></tr>
<tr><td>02</td><td>02:00 – 02:59</td><td>14</td><td>02:00 – 02:59</td></tr>
<tr><td>03</td><td>03:00 – 03:59</td><td>15</td><td>03:00 – 03:59</td></tr>
<tr><td>04</td><td>04:00 – 04:59</td><td>16</td><td>04:00 – 04:59</td></tr>
<tr><td>05</td><td>05:00 – 05:59</td><td>17</td><td>05:00 – 05:59</td></tr>
<tr><td>06</td><td>06:00 – 06:59</td><td>18</td><td>06:00 – 06:59</td></tr>
<tr><td>07</td><td>07:00 – 07:59</td><td>19</td><td>07:00 – 07:59</td></tr>
<tr><td>08</td><td>08:00 – 08:59</td><td>20</td><td>08:00 – 08:59</td></tr>
<tr><td>09</td><td>09:00 – 09:59</td><td>21</td><td>09:00 – 09:59</td></tr>
<tr><td>10</td><td>10:00 – 10:59</td><td>22</td><td>10:00 – 10:59</td></tr>
<tr><td>11</td><td>11:00 – 11:59</td><td>23</td><td>11:00 – 11:59</td></tr>
</table>
</td></tr>
</table>

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
19. Admission Type	Required (hospital)	Indicate the applicable code for all inpatient visits. A "1" must be used to indicate an emergency department visit that meets emergency criteria to ensure that a co-payment amount is not deducted during the claim processing. 1 **Emergency:** The patient requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency department. 2 **Urgent:** The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation. 3 **Elective:** The patient's condition permits adequate time to schedule the availability of a suitable accommodation. 4 **Newborn:** Any newborn infant admitted to the hospital within the first 24 hours of life.
20. Source of Admission	Required (hospital)	1 **Physician Referral:** Inpatient: The patient was admitted to this facility upon the recommendation of their personal physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by their personal physician or the patient independently requested outpatient services (self-referral). 2 **Clinic Referral:** Inpatient: The patient was admitted to this facility upon recommendation of **this facility's clinic physician**. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services **by this facility's clinic or other outpatient department physician.**

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
20. Source of Admission, continued	Required (hospital)	3. **HMO Referral:** Inpatient: The patient was admitted to this facility upon the recommendation of a health maintenance organization physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a health maintenance organization physician. 4 **Transfer From a Hospital:** Inpatient: The patient was admitted to this facility as a transfer from an acute care facility where they were an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility. 5 **Transfer From a Skilled Nursing Facility:** Inpatient: The patient was admitted to this facility as a transfer from a skilled nursing facility where they were an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the skilled nursing facility they were an inpatient. 6 **Transfer From Another Health Care Facility:** Inpatient: The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long-term care facilities, and skilled nursing facility patients that are at a nonskilled level of care. Outpatient: The patient was referred to this facility for outpatient services or referenced diagnostic services by a physician of another health care facility where they are an inpatient.

UB-92 Claim Form Instructions, continued

<table>
<tr><th>Form Locator/Description</th><th>Requirements</th><th>Explanation</th></tr>
<tr><td>20. Source of Admission, continued</td><td>Required (hospital)</td><td>7 Emergency Department:

Inpatient: The patient was admitted to this facility upon the recommendation of this facility's emergency department physician.

Outpatient: The patient was referred to the facility for outpatient services or referenced diagnostic services by this facility's emergency department physician.

For Newborns:

1 Normal Delivery: A baby delivered without complications.

2 Premature Delivery: A baby delivered with time or weight factors qualifying it for premature status.

3 Sick Baby: A baby delivered with medical complications, other than those relating to premature status.

4 Extramural Birth: A baby born in a nonsterile environment.

5 - 8 Reserved For National Assignment

9 Information Not Available</td></tr>
<tr><td>21. Discharge Hour</td><td>Required (hospital)</td><td>
<table>
<tr><th>Time Code</th><th>AM</th><th>Time Code</th><th>PM</th></tr>
<tr><td>00</td><td>12:00 – 12:59 midnight</td><td>12</td><td>12:00 – 12:59 noon</td></tr>
<tr><td>01</td><td>01:00 – 01:59</td><td>13</td><td>01:00 – 01:59</td></tr>
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<tr><td>07</td><td>07:00 – 07:59</td><td>19</td><td>07:00 – 07:59</td></tr>
<tr><td>08</td><td>08:00 – 08:59</td><td>20</td><td>08:00 – 08:59</td></tr>
<tr><td>09</td><td>09:00 – 09:59</td><td>21</td><td>09:00 – 09:59</td></tr>
<tr><td>10</td><td>10:00 – 10:59</td><td>22</td><td>10:00 – 10:59</td></tr>
<tr><td>11</td><td>11:00 – 11:59</td><td>23</td><td>11:00 – 11:59</td></tr>
</table>
</td></tr>
</table>

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
22. Patient Status	Required (except for ambulance and personal care services)	01 Discharged to home or self care (routine discharge). 02 Discharged/transferred to another short-term general hospital. 03 Discharged/transferred to skilled nursing facility. 04 Discharged/transferred to an intermediate care facility. 05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution. 06 Discharged/transferred to home under care of organized home health service organization. 07 Left against medical advice. 08 Discharged/transferred to home under care of a home IV provider. 20 Expired. 30 Still a patient or expected to return for outpatient services. 61 Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed. 62 Discharged/transferred to another rehabilitation facility including rehabilitation-distinct part units of a hospital. 63 Discharged/transferred to a long-term care hospital. 64 Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare.
23. Medical Record Number	Optional	If a number is entered, it will not appear on the RA.

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
24. - 30. Condition Codes	Required, where applicable	D7 **Medicare Part A noncovered service or does not meet Medicare criteria for Part A.** D9 **Medicare Part B noncovered service or does not meet Medicare criteria for Part B.** Refer to the **July 1999** ***N.C. Medicaid Ambulance Services Manual*** for applicable ambulance condition codes. **Note:** Condition codes should not be entered for entitlement issues.
32. - 35., a - b Occurrence Codes and Dates	Required, where applicable	**Accident Related Codes:** 24 **Date Insurance Denied:** This code should be used when a provider receives a denial from the recipient's third party insurance. It allows the provider to file the claim to Medicaid without a voucher attached. This code allows the TPL indicator to override during claim processing. When using this code, enter the date from the third party insurance EOB. 25 **Date Benefits Terminated By Primary Payer:** This code should be used when a recipient's third party insurance has been terminated. It allows the provider to file the claim to Medicaid without a voucher attached. This code allows the TPL indicator to override during claim processing. When using this code, enter the date from the third party insurance EOB. **Note:** Medicare crossover claims require a paper insurance denial.

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
32. - 35., a - b **Occurrence Codes and Dates**, continued		**Special Codes:** A3 **Benefits Exhausted:** Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer A. B3 **Benefits Exhausted:** Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer B. C3 **Benefits Exhausted:** Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer C. 11 **Date of Initial Treatment:** Providers should use this code to indicate the first date of dialysis treatment
39. - 41., a - d **Value Codes and Amounts**	Required, where applicable	Values codes and amounts only pertain to a long-term care facility, hospital, psychiatric residential treatment facility or, if the recipient lives in a nursing facility, a hospice. Enter any value code pertinent to this claim. Applicable deductible/patient liability amounts should be indicated with a value code of 23. 23 **Recurring Monthly Income:** This code indicates that the Medicaid eligibility requirements are determined at the state level. **Note:** Include code 23 and value (even if it is 0) for any inpatient stay extending beyond the first of the month following the 30th consecutive day of admission.
42. Revenue Code	Required	Enter the appropriate revenue code. Refer to program-specific Medicaid services information for applicable codes. Revenue code 634 is required for dialysis treatment centers.
43. Revenue Code Description	Not required	
44. HCPCS/Rates	Required, where applicable	Enter the appropriate revenue code. Refer to program-specific Medicaid services information for applicable codes.

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
45. Service Date	Required, where applicable	Enter an eight-digit service date for each line item billed. Required if multiple dates of services are billed on one outpatient claim. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
46. Unit of Service	Required, where applicable	Enter the number of units for each detail line. Refer to program-specific Medicaid services information on how a unit is defined.
47. Total Charges	Required	Enter the total of the amounts in this column. Enter the revenue code 001 on the corresponding line in form locator 42.
50. A, B, C Payer	Required	Enter the Payer Classification Code and Specific Carrier Identification Code for each of up to three payers. List the payers in order of priority: A Primary payer B Secondary payer C Tertiary payer The information entered on lines A, B, and C must correspond with the information in form locators 37, and 52 through 66. **Note:** Effective with date of service October 1, 2002, Medicare Part B payer codes M0000 must be indicated. **Payer Classification Codes** Medicare M Medicaid D Blue Cross B Commercial Insurance I Tricare C NC DHHS-Purchase of Care N Worker's Compensation W State Employee Health Plan E Administered Plans S Health Maintenance Organization H Self-Pay/Indigent/Charity P Other O

UB-92 Claim Form Instructions, continued

<table>
<tr><th>Form Locator/Description</th><th>Requirements</th><th>Explanation</th></tr>
<tr><td>50. A, B, C Payer, continued</td><td></td><td><u>Specific Carrier Identification Codes</u>
<table>
<tr><th>Payer Classification</th><th>Carrier Code</th><th>Explanatory Notes</th></tr>
<tr><td>Medicare (M)</td><td>0000</td><td>4 zeros</td></tr>
<tr><td>Medicaid (D)</td><td>XX00</td><td>Where XX = postal state code (example: NC00)</td></tr>
<tr><td>Blue Cross (B)</td><td>0XXX</td><td>Where XXX = Blue Cross Plan Code or FEP</td></tr>
<tr><td>Commercial Insurer (I)</td><td>XXXX</td><td>Where XXXX = Docket Number</td></tr>
<tr><td>Commercial Insurer (I)</td><td>9999</td><td>When Docket Number is unassigned</td></tr>
<tr><td>Tricare (C)</td><td>0000</td><td>4 zeros</td></tr>
<tr><td>NC DHHS – Purchase of Care</td><td>0000</td><td>4 zeros</td></tr>
<tr><td>Worker's Compensation</td><td>XXXX</td><td>Where XXXX = Docket Number</td></tr>
<tr><td>Worker's Compensation</td><td>9999</td><td>When Docket Number is unassigned</td></tr>
<tr><td>State Employees Health Plan</td><td>0000</td><td>4 zeros</td></tr>
<tr><td>Administered Plan (S)</td><td>0000</td><td>4 zeros</td></tr>
<tr><td>Health Maintenance Organization (H)</td><td>XXXX</td><td>Where XXXX = Docket Number</td></tr>
<tr><td>Health Maintenance</td><td>9999</td><td>When Docket Number is unassigned</td></tr>
<tr><td>Self-Pay/Indigent/ Charity (P)</td><td>6666</td><td>Self-pay-hospital bills patient and expects payment</td></tr>
</table></td></tr>
<tr><td>51. A, B, C Provider Number</td><td>Required</td><td>Enter the Medicaid number as shown on the RA. Do not use extra zeros or dashes.</td></tr>
</table>

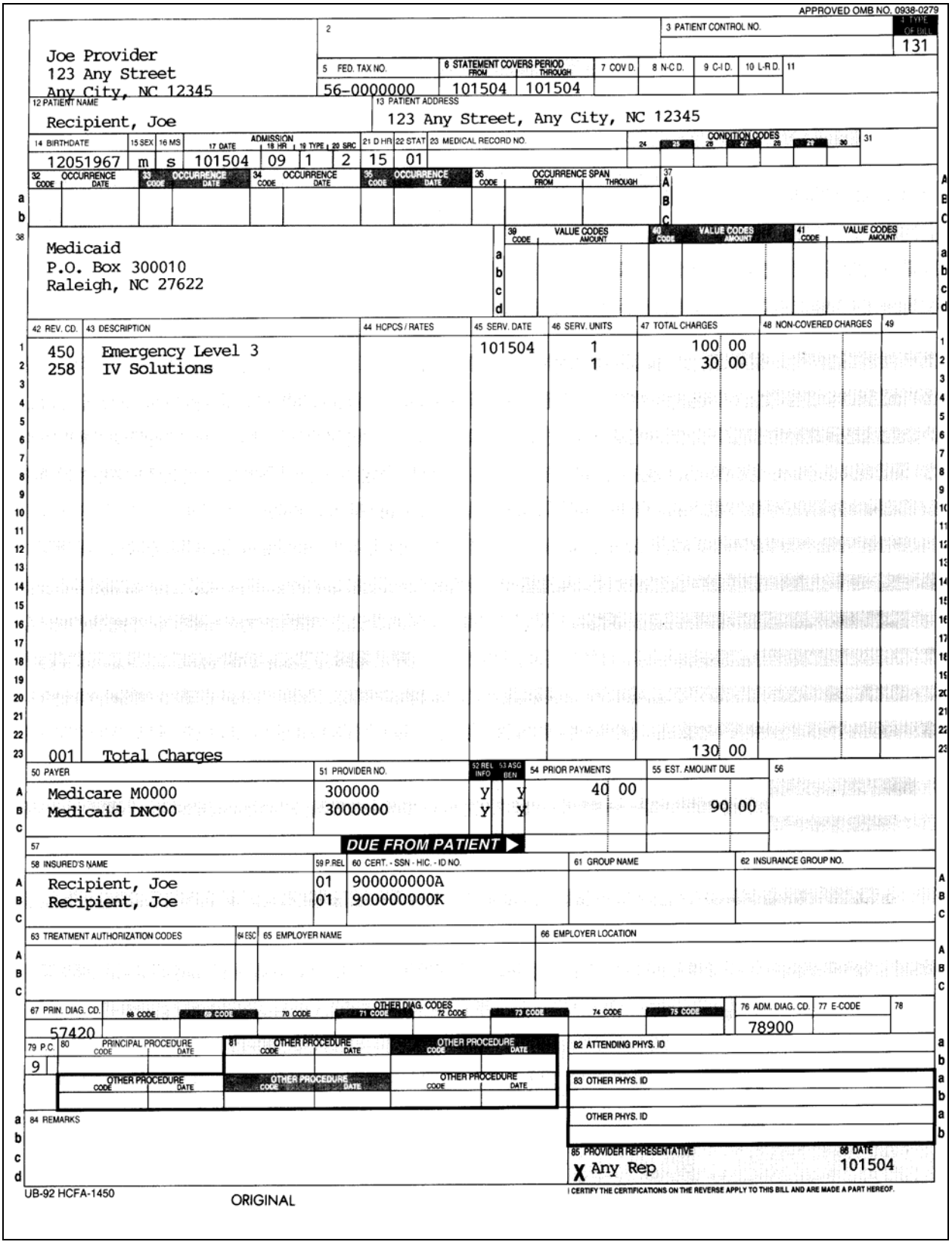
UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
54. A, B, C Prior Payments (from Payers)	Required, where applicable	For dates of service **before** October 1, 2002, enter any applicable third party amount. Enter the Medicare Part B payment amount in this block for hospital inpatient claims when Part A benefits are exhausted or not applicable to the claim. For dates of service **after** October 1, 2002: 54A Enter any applicable Medicare payment or third party. 54B If the Medicare payment is indicated in field locator 54A, enter any applicable third party payments in form locator 54B. The Medicare Part B payment amount should be entered for hospital inpatient claims when Part A benefits are exhausted or not applicable to the claim. Include penalties and outpatient psychiatric reductions with Medicare part B payments. Refer to the **September 2002 Draft Special Bulletin IV (Revised November 14, 2002)** ***Medicare Part B Billing Guidelines*** for detailed instructions on billing for Medicare Part B. Amounts entered in this block will be deducted from allowable payment.
55. Estimated Amount Due	Required (hospital outpatient)	For claims filed to Medicaid for dates of service **after** October 1, 2002, where Medicare Part B has made a payment, enter the sum of both the coinsurance and the deductible.
60. A, B, C Certificate/Social Security/ Health Insurance Claim/ Identification Number	Required	Enter the ten-character MID number as indicated on the recipient's MID card.
63. A, B, C Treatment Authorization Code	Not Required	It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file.
67. Principal Diagnosis Code	Required	Enter the applicable ICD-9-CM diagnosis code.
68. - 75. Other Diagnosis Codes	Required, where applicable	Enter any additional diagnosis codes.

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
76. Admitting Diagnosis	Required, inpatient only	Enter the ICD-9-CM code for the admitting diagnosis.
80. Principal Procedure Code and Date	Required, where applicable	Enter the codes for any surgical or diagnostic procedures performed during this period. Use only ICD-9-CM procedure codes. Enter the eight-digit date of service. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
81. Other Procedure Codes and Dates	Required, where applicable	Enter the codes for any additional surgical or diagnostic procedures performed during this period. Enter the eight-digit date of service. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
83. b Other Phys. ID	Required, where applicable	**For paper claims for services provided to CA enrollees, enter the PCP referral authorization here.** **For electronic claims, enter the PCP's referral authorization in field locator 11.**
84. Remarks	Required, where applicable	Enter any information applicable to the specific claim billed.
85. Provider Representative Signature	Required	The physician, supplier or an authorized representative must either: 1. sign and date all claims, or 2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or 3. if a Certificate of Signature on File has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.
86. Date Bill Submitted	Desired	Enter date the claim was submitted.

Sample UB-92 Claim Form



APPROVED OMB NO. 0938-0279

1 PROVIDER NAME, ADDRESS, PHONE	Joe Provider 123 Any Street Any City, NC 12345
2	
3 PATIENT CONTROL NO.	
4 TYPE OF BILL	131
5 FED. TAX NO.	56-0000000
6 STATEMENT COVERS PERIOD FROM	101504
6 STATEMENT COVERS PERIOD THROUGH	101504
7 COV D.	
8 N-C D.	
9 C-I D.	
10 L-R D.	
11	
12 PATIENT NAME	Recipient, Joe
13 PATIENT ADDRESS	123 Any Street, Any City, NC 12345
14 BIRTHDATE	12051967
15 SEX	m
16 MS	s
17 ADMISSION DATE	101504
18 HR	09
19 TYPE	1
20 SRC	2
21 D HR	15
22 STAT	01
23 MEDICAL RECORD NO.	
24-30 CONDITION CODES	
31	
32-36 OCCURRENCE / OCCURRENCE SPAN	
37	
38	Medicaid P.O. Box 300010 Raleigh, NC 27622
39 VALUE CODES / AMOUNT	
40 VALUE CODES / AMOUNT	
41 VALUE CODES / AMOUNT	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
450	Emergency Level 3		101504	1	100 00		
258	IV Solutions			1	30 00		
001	Total Charges				130 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicare M0000	300000	y	y	40 00	90 00	
Medicaid DNC00	3000000	y	y			

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Recipient, Joe	01	900000000A		
Recipient, Joe	01	900000000K		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68	69	70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E-CODE	78
57420									78900		

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	82 ATTENDING PHYS. ID
9				
	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	83 OTHER PHYS. ID
				OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
	X Any Rep	101504

UB-92 HCFA-1450 ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample UB-92 Claim Form

UNIFORM BILL: NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935l, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.
   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

Billing on the ADA Claim Form

Listed below are some of the provider types who bill on the American Dental Association (ADA) claim form:

dentist
federally qualified health center (dental services only)
health department dental clinics (dental services only)
rural health clinic (dental services only)

Refer to Clinical Coverage Policy # 4, Dental Services, on DMA's website at: https://www.dhhs.state.nc.us/dma/mp/mpindex.htm for instructions on completing the ADA claim form.

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

PROVIDER CERTIFICATION
FOR
SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

SIGNATURE:

_____

Print or Type Business Name of Provider

_____

Signature of Provider Date

Group provider number to which this certification applies: _____

Attending provider number to which this certification applies: _____

Return completed form to: EDS
Provider Enrollment
P.O. Box 300009
Raleigh, NC 27622

Sample of Medicare Crossover Reference Request

Provider Name: _____

Contact Person (required): _____ Telephone (required): _____

Select the appropriate *Medicare Carrier/Intermediary/DMERC* from the following listing, the *Action to be take*n, and your *Medicare* and *Medicaid* provider numbers. **If this section is not completed, the form will not be processed.** These are the only carriers for which EDS can currently cross-reference provider numbers.

Medicare Part A Intermediaries

- ☐ Riverbend GBA Medicare Part A (Tennessee) http://www.riverbendgba.com
- ☐ Palmetto GBA Medicare Part A. Effective November 1, 2001, Palmetto GBA assumed the role of North Carolina Part A intermediary from Blue Cross/Blue Shield of NC. (North Carolina) http://www.palmettogba.com
- ☐ Trailblazer Medicare Part A (Colorado, New Mexico and Texas) http://www.the-medicare.com
- ☐ United Government Services Medicare Part A (Wisconsin) http://www.ugsmedicare.com
- ☐ Palmetto Medicare Part A (South Carolina) http://www.palmettogba.com *
- ☐ AdminaStar Medicare Part A (Illinois, Indiana, Ohio, and Kentucky) http://www.astar-federal.com *
- ☐ Carefirst of Maryland Medicare Part A (Maryland) http://www.marylandmedicare.com *
- ☐ Veritus Medicare Part A (Pennsylvania) http://www.veritusmedicare.com *
- ☐ First Coast Service Options Medicare Part A, subsidiary of BCBS of Florida (Florida) http://www.floridamedicare.com *

Medicare Part B Carrier

- ☐ CIGNA Medicare Part B (Tennessee, North Carolina, and Idaho) http://www.cignamedicare.com
- ☐ AdminaStar Medicare Part B (Indiana and Kentucky) http://www.astar-federal.com*
- ☐ Palmetto Medicare Part B (South Carolina) http://www.palmettogba.com*

Medicare Regional DMERC

- ☐ Palmetto Region C DMERC (Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas and the Virgin Islands) http://www.palmettogba.com

*Trading Partners currently in testing phase.

Action to be taken:

☐ ***Addition*** *- This is used to add a new provider number (Medicare or Medicaid) to the crossover file.*

Medicare Provider number: _____ Medicaid Provider number: _____

☐ ***Change*** *- This is used to change an existing provider number (Medicare or Medicaid) on the crossover file.*

Medicare Provider number: _____ Medicaid Provider number: _____

Mail completed form to: EDS - Provider Enrollment
PO Box 300009
Raleigh, NC 27622

or Fax: 1-919-851-4014

1-800-688-6696 Revised (03/06)